EMERGENCY EPINEPHRINE TRAINING PROGRAM APPLICATION

Department of Health & Mental Hygiene (DHMH)
Center for Healthy Homes and Community Services (CHHCS)
6 St. Paul Street, Suite 1301
Baltimore, Maryland 21202-1608
(410) 767-8417 FAX (410) 333-8926
Toll Free 1-877-4MD-DHMH ext. 8417

I. APPLICANT INFORMATION

APPLICANT'S NAME			
APPLICANT'S MAILING ADDRESS			APPLICANT'S WORK PHONE
CITY	STATE	ZIP CODE	APPLICANT'S CELL PHONE
APPLICANT'S EMAIL			

II. BUSINESS INFORMATION

BUSINESS NAME			
BUSINESS MAILING ADDRESS	CITY	STATE	ZIP CODE
NAME OF TRAINING			

III. INSTRUCTOR CREDENTIALS *(FOR EACH ADDITIONAL INSTRUCTOR SUBMIT INFORMAITON ON ANOTHER SHEET OF PAPER)*

INSTRUCTOR'S NAME

WHICH LICENSE TYPE DO YOU HOLD?

☐ PHYSICIAN ☐ REGISTERED NURSE ☐ CERTIFIED NURSE PRACTITIONER

LICENSE NUMBER:

IV. WRITTEN MATERIALS

SUBMIT COPIES OF THE FOLLOWING FOR REVIEW:

A) Training manual, to include all requirements list in COMAR 10.16.07.15D

B) All handouts

B) All presentations

C) All exams

D) Certificate issued to student upon completion

V. APPLICANT'S SIGNATURE

I have carefully examined and read this application and when teaching, agree to comply with all applicable laws and COMAR 10.16.07 of the State of Maryland regarding emergency epinephrine at youth camps. I understand that providing false information on this application or violating, Maryland Health-General Code Annotated Title 13, Subtitle 7; Title 14, Subtitle 4; or any regulation adopted by the Department under these subtitles may result in suspension or revocation of my course approval. *If you have questions, please call DHMH, Center for Healthy Homes and Community Services at (410) 767-8417 or 1-877-4MD-DHMH ext. 78417.*

X _____ **DATE** _____

APPLICANT'S SIGNATURE

FOR INTERNAL USE ONLY *(Do Not Write Below This Line)*

☐ APPROVED ☐ DENIED Reason:_____ TRACKING #:_____

X _____ **DATE** _____

EHB DIRECTOR'S SIGNATURE